Colorado Department of Human Services Child Fatality/Near Fatality/Egregious Incident Case-Specific Executive Review Report NON-CONFIDENTIAL

investigating County Name: Adams County Human Services Department					
Public Notification Case ID: 12-005					
Type of report: Fatality Date: 3/30/2012 D	Near Fatality Oate:	Egregious Incident Date:			
24-hour Initial County Notificati	on Date: <u>3</u>	<u> </u>			
3 day Public Disclosure	Date: <u>N</u>	<u>V/A</u>			
⊠ 60-day County Update/Internal	review Date: 5	<u>//4/2012</u>			
☐ Final Confidential Case Specific Child Fatality Review Report Date: 4/23/2013					
Final Non-Confidential Case Specific Child Fatality Review Report Date: 4/23/2013					

~PUBLIC DISCLOSE NOTICE~

This report, outlining the non-confidential findings or information regarding a child fatality or near fatality which occurred as the result of child abuse or neglect within a family who was involved with a County Department of Human/Social Services within two years prior to the incident, is subject to public disclosure in accordance with Federal requirements under the Child Abuse Prevention and Treatment Act (CAPTA 42 U.S.C. 5106 § a (b)(2)(A)(x)(2006).

In order to protect the rights of the involved child/ren and family members and preserve the confidentiality of child abuse and neglect reports and records, the following information will not be released and will be redacted where it is deemed necessary in accordance to CAPTA: (1) Any identifying information of the child who is subject to the report, any member of the child's family, any member of the child's household, or any caregiver of the child; (2) Any identifying information regarding the person(s) suspected of the abuse or neglect; (3) Any identifying information regarding the reporter of the suspicion of abuse or neglect; (4) Any identifying information of any employee of any agency that provided services for the child or child's family or that participated in the investigation of the child fatality or near fatal incident or any previous investigation involving the child or child's family; (5) Any information the disclosure of which would not be in the best interests of the child who is the subject of the report or any member of his/her family; (6) Any information that may adversely affect a pending criminal investigation and/or proceeding; and (7) any other disclosure which violates any other state or federal confidentiality laws including, but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), titles IV-B/IV-E of the Social Security Act, and any other applicable law.

Portions of information on this form	have been	withheld a	t the reques	t of (name	of the agency):
Not applicable					

I. IDENTIFYING INFORMATION

A. Child victim

Age: 7 months **Gender:** Male Female **Race or ethnicity:** Black

Special needs: None known

B. Names of parents

Mother

Age: 22 Race or ethnicity: Black

Father

Age: 26 **Race or ethnicity**: <u>unknown</u>

C. Description of the child's family (non-identifying information):

The mother is a single mother of the victim and his two older siblings. The child's father had occasional visits with him.

II. FATALITY/ NEAR FATALITY/ EGREGIOUS INCIDENT SUMMARY

A. Referral/Assessment Date: 3/30/2012

B. Description of the incident, including the suspected cause of death, near fatality, or egregious incident (non-identifying information):

While meeting with a life skills coach contracted by Adams County Human Services Department (Department) on 3/29/2012 the mother told the life skills coach the maternal grandfather came into town and took the mother's seven-month-old child home with him to another state. The life skills coach questioned the validity of the mother's statement because much of the child's clothing, bottles, and toys were still at the mother's home. The life skills coach called the assigned caseworker at the Department immediately after leaving the mother's home to verify whether or not the mother informed her she allowed the child to leave the state.

The caseworker immediately called the mother and confronted her regarding what she told the life skills coach and questioned where the child was. The mother confirmed the child was with the maternal grandfather. The grandfather later called the caseworker and stated he is an over-the-road truck driver and was in fact in Tennessee and the child was not with him. The caseworker then called the child care center to determine if the child was at day care, he was not. The mother then called the caseworker back and stated the child would not stop crying so she took him to a park on 3/6/2012 and left him by the slide. She stated she returned later that evening and he was no longer there.

The Department called Aurora Police Department, the law enforcement jurisdiction where the park is located. They also contacted Commerce City Police Department due to concerns the mother's story was not adding up and fear she may have done something to the child in the home. Commerce City Police indicated Aurora Police Department would be the lead jurisdiction. A welfare check on the mother was then requested of the Commerce City Police. The police responded to the mother's home and given some of the comments she made, Commerce City Police decided to take her in for further questioning.

During interviews with law enforcement the mother admitted that after a lengthy time of listening to the child cry, being unable to soothe him, and having not slept well herself, she placed the child face down in his bassinet, piled clothing on top of him, and left the child there for several hours. When she returned the child was cold and not breathing. She placed the child's body in a book

bag and placed the bag in the dumpster. The child's remains were found in a landfill approximately two months later on May 30, 2012. At the time of review the autopsy had not yet been completed but the presumed cause of death is asphyxiation.

C. Is the county department investigating this child's death/near fatal injury/egregious incident?

	⊠ Yes
	Actions taken by county in response to child's death/near fatal injury/egregious incident (non-identifying information): On 4/24/2012, the Department filed a Dependency and Neglect petition with the court with regard to the surviving siblings temporary custody was granted to a relative who had been caring for the children since the victim's disappearance. The ongoing case remains open and the surviving siblings are receiving appropriate services. The children's mother remains in jail.
	\square No, why not:
	☐ No surviving siblings Other:
D.	Child's residence: ⊠ In-home ☐ Out of home care placement by county
E.	Findings made by county, including material circumstances leading to incident:
	The Department made a founded finding of fatal physical abuse by the mother. A founded finding of neglect, injurious enviornment by the mother towards the two surviving siblings was also made.
Ш	. CURRENT AND PREVIOUS INVOLVEMENT WITH DHS
A.	Open Involvement (involving individuals in this family composition, household, and/or same alleged perpetrator):
	Case Date opened: 12/14/2011 County: Adams County
	Current status of case including services being provided, placement, other agency involvement (non-identifying information): A voluntary (non-court involved) case was opened after the 11/30/2011 assessment to provide services and supports to the family. The case was transferred to the Family Assessment and Stabilization Team (FAST) for life skills, mental health monitoring, to address the family's basic needs (provide funds for birth certificates, a bassinet, formula, transportation, and daycare), and to resolve child safety concerns. A Family Team Meeting (FTM) was scheduled for 12/19/2011 with the assigned caseworkers, supervisor, the mother, father of the youngest child, and the mother was encouraged to invite family members and other supports. A case-aide went to the family home to pick everyone up for the FTM although no one was home. Later that day the caseworker went to the family home to check on the family and found no one was home. The following day the caseworker

again returned to the family home. The mother was home and apologized for missing the meeting explaining she could not attend because she started working for the landlord although she believed it wasn't going to work out. The family home was in disarray with clothing and trash on the floors. She indicated she and her relatives decided the children and the maternal

grandmother (who came into town to help the mother) could care for the children since she

uncle would move to the maternal great uncle's home. He and the maternal great-

would soon be evicted. The caseworker and mother set up another FTM date and the mother signed a release of information so the caseworker could talk with the maternal great-grandmother who recently came into town. The mother provided the caseworker with the great-grandmother's contact information.

The same day the caseworker went to the relative's home and visited with both relatives and the children. The caseworker noted no concerns regarding the children. The caseworker explained the reason for the Department's involvement which the mother had not previously shared. The maternal great-grandmother was shocked and indicated having no knowledge of any prior mental health issues with the mother. The relatives were happy to help with the children in any way needed. The caseworker later modified the original safety plan to indicate either of the relatives would provide care and supervision for all three children. The mother was allowed to visit with the children as long as supervision was being provided by one of the relatives. The relatives agreed to their responsibilities as outlined by the modifications made to the safety plan.

On 12/23/2011 a FTM was held, involving the Department, the mother, maternal great-grandmother, maternal uncle, and mother's boyfriend, to discuss the safety concerns and the ongoing needs of the family. The youngest child's father was invited although was unable to attend. The Department explained the purpose and objectives of FAST. FAST is an intensive, non-court involved program that works towards resolving identified child protection concerns. The FAST intervention is designed to be short term and may last up to six months. Families are asked to agree to meeting with the caseworker at least three times a month in addition to meeting with community resource and service providers. FAST is the lowest level, most intensive, non-court involved level of intervention the Department offers. If, after the family has worked with FAST and the child protection concerns are not resolved and/or the family needs additional services, then the family's case will be assessed for a higher level of intervention which could include being referred to another on-going unit for extended services and/or court intervention.

The mother was facing eviction and feeling very overwhelmed about her ability to parent her children given her circumstances. The caseworker informed the mother of the Family Unification Program (FUP) which is a program designed to target financial assistance and services to families whose lack of adequate housing is the primary factor in the separation of the children from their families. The mother and caseworker completed the initial paperwork although the mother needed to get copies of the children's birth certificates before the paperwork could be turned in. The participants in the FTM developed a treatment plan indicating the relatives would continue providing care to the children and supervising all contact the children have with their mother. The Department agreed to provide Special Circumstance Child Care for all three children to assist the relatives in the caretaking responsibilities. The plan indicated the mother would schedule and begin participating in mental health services (this was also a part of the safety plan), continue with her college classes or secure employment and participate in the in-home services provided by the Department. The plan indicated the Department would coordinate with the mother's benefit technicians (TANF, Medicaid, food stamps, WIC and housing) to ensure the mother completed the necessary paperwork and took the necessary classes to maintain her benefits in order to provide for her children. Additionally, the Department would assist the mother in setting up mental health services from the community mental health center as recommended by the hospital therapist, provide case aide assistance (transportation, assist with completing benefit paperwork, and follow-up), provide the mother with a monthly bus pass, and contract services from a community agency to provide intensive in-home parenting education and organizational and life skills training.

During the FTM it was determined the initial focus needed to be stabilizing the mother by ensuring her basic needs were met and mental health services were in place and would defer

implementing in-home service until the mother's housing situation was stable and she was able to provide care for her children. Referrals for FUP, mental health services and Special Circumstance Child Care were completed by the caseworker.

The mother was evicted from her apartment and moved into the home with her relatives and children at the beginning of February 2012. The expectation became that the mother provide all of the caregiving responsibilities for her children while the relatives provided support and supervision. On 2/15/2012 the mother moved into a new two bedroom apartment in Commerce City, moving her from her community in Aurora where she had daycare, family support, and other connections. The children were allowed to return to her care on 2/20/2012. The mother had been providing care to her children under the supervision of relatives since 2/1/2012 with no concerns noted in the case record. She also no longer had the stress of being evicted and was again receiving financial assistance. According to the case record, the mother completed her intake appointment at the mental health center on 12/7/2011. She did not attend the follow-up appointments scheduled for 12/20/2011 or 1/19/2012 due to confusion about the appointment dates. The mother went to the mental health center on 2/15/2012 however was late for her appointment due to having to take two buses to reach the mental health center. According to the case record, she was informed she needed to reschedule her appointment and begin the intake process over due to her arriving late for the appointment. This appointment was set for 2/23/2012. Due to the missed appointments mental health services did not begin until after the children returned home. A referral to the in-home service provider was made on 2/22/2012 and assigned to a worker within the program on 3/5/2012. The life skills coach met with the mother two times and had another visit scheduled with the mother that the mother indicated she forgot about. During the last visit the mother had with the life skills coach on 3/29/2012 the mother reported allowing the maternal grandfather to take her son home with him to another state. This information prompted the investigation into the death of the mother's son.

B. Closed Involvement within the last two years (involving individuals in this family composition, household, and/or same alleged perpetrator, history is most recent to oldest):

1. Referral/Assessment

Accepted for asses	sment: XYes	□No	Date opened: <u>11/30/2011</u>	Date closed: 1/6	/2012
County: Adams	Findings: Inc	conclusi	ve for neglect		

Referral narrative, assessment summary (non-identifying information):

A referral was received after law enforcement responded to the home on 11/30/2011 to check on the welfare of three young children after they were informed the mother told a friend she wanted to smother her youngest child because she "couldn't do it any more". The friend stated the mother was distraught and depressed. When law enforcement arrived at the home they found the youngest child asleep on the bed. The two siblings denied their mother tried to hurt their brother. The mother stated she made the comments out of frustration because she just found out she didn't get the job she was hoping to get and was not going to be able to pay her rent. The officer reported the children all appeared clean, healthy, and happy. The home was fairly clean and there was plenty of food. The mother agreed to being transported to the hospital for an evaluation. The paternal grandmother agreed to care for all three children for the night. The evaluation was completed; the mother was discharged from the hospital and recommended she participate in ongoing mental health services due to an acute stress reaction.

The caseworker responded to the mother's home the following day on 12/1/2011. The mother denied she would ever hurt any of her children explaining she made the comments because felt overwhelmed because she didn't have a job and would probably lose her housing because she was unable to pay her rent. At that time the mother was receiving

food stamps, Medicaid, and TANF, but indicated she was going to be sanctioned because she missed several of the required classes. She indicated having an upcoming appointment with the Adams County Housing Authority to receive subsidized housing but indicated she'd probably be placed on a waiting list. She also identified that a majority of her stress comes from the ongoing discord between her and the youngest child's father. She reported her financial struggles cause a great deal of stress and she does not receive any financial assistance from any of the children's fathers. The mother denied having a criminal history, substance abuse problems, or receiving any previous mental health services. The caseworker completed an assessment of risk of future harm and current safety concerns. The risk assessment indicated a moderate level of risk for future harm. The safety assessment identified a safety concern given the mother made a threat of harm toward her youngest child. The caseworker determined a safety plan could be developed to control for the identified safety concern because the mother had relatives available and willing to immediately assist her. The mother and a relative were willing to accept and cooperate with the plan, and the family and the Department had the resources accessible to control for the safety concern without placing that responsibility on the mother. The safety plan the family and caseworker developed required the relative move into the family home and be solely responsible for the children at all times therefore being responsible to supervise any contact the mother had with her children. Additionally, the plan indicated the Department would open a voluntary (non-court involved) case to provide services to the family from the Department's FAST.

2. Referral/Assessment

Accepted for asses	ssment: XYes	□No	Date opened: <u>5/27/2011</u>	Date closed: <u>6/30/2011</u>
County: Adams	Findings: Unf	founded	for neglect	

Referral narrative, assessment summary (non-identifying information):

An anonymous report was received by the Department on 5/27/2011 stating the mother of the children is four months pregnant, drinking heavily, and leaving the children alone for periods of time. The Department requested Aurora Police Department respond to the home to check on the welfare of the children, ensuring the children were not currently home alone or if they were home with their mother she was not under the influence of any substances.

Law enforcement completed the welfare check on 5/27/11 and found the mother home with her children. According to the police, there was no evidence she was under the influence of any substances and the children appeared well cared for.

The caseworker followed up and attempted two unannounced home visits on 6/6/11 and 6/15/11, with no success in locating the family. On the third visit to the home (6/17/11) the caseworker made contact with the mother and her two children. The mother denied the allegations made against her and did not know who would have made such a report. The mother explained she has lived in Colorado since 2008 and only has one relative in the area. The relative is a support to her and will occasionally watch the children for her on the weekends. The children also attend daycare Monday through Friday (this information was not verified by the caseworker). She denied ever leaving them home alone. The mother denied using alcohol or drugs. The caseworker believed the children appeared healthy and well cared for. The only child old enough to be interviewed made no statements concerning abuse or neglect. The caseworker completed assessments of risk of harm and current safety concerns. The risk assessment indicated a moderate level of risk for future harm due to there being two children under the age of two in the home. There were no identified safety concerns. The caseworker concluded a preponderance of evidence did not exist to support the allegations of neglect, injurious environment and the assessment was

closed at intake.

IV. COUNTY INTERNAL REVIEW

Date/s: May 4, 2012

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: 7/9/2012

Documents Reviewed:

- 1. Trails referrals, assessments, and case report.
- 2. Adams County Human Services Department Internal Fatality Review.
- 3. Volume VII State Child Welfare Rules and Regulations.

B. Summary of identified systemic strengths in the delivery of services and supports to child/ren and/or family (non-identifying information).

The CDHS Child Fatality Review Team reviewed the fatality and the county's prior involvements with the family and identified several strengths in the delivery of services and supports to the children and family. These strengths are outlined below:

- 1. The mother was immediately evaluated at the hospital when she made the initial threat.
- 2. The Department modified the safety plan to include the maternal great-grandmother of the children when she came to town to help the mother with her children.
- 3. In-home services were provided to support the family even though the assessment findings were inconclusive.
- 4. The Department utilized their county design FAST team to provide intensive services and supports to the family.
- 5. The involved caseworkers made contact with the family at least three times per month, exceeding the policy standard of monthly contact.
- 6. The surviving children were placed with the same family members they had previously lived with.

C. Summary of identified systemic gaps and deficiencies in the delivery of services and supports to child/ren and/or family (non-identifying information).

The CDHS Child Fatality Review Team reviewed the fatality and the county's prior involvements with the family and identified several systemic gaps and deficiencies in the delivery of services and supports to the family. These gaps are outlined below:

- 1. It was difficult for this mother to access mental health services (scheduling, transportation, and missed appointments). If appointments are missed or the client is late the intake/referral process starts over. This caused a delay in the mother receiving the necessary mental health services. Also, the mental health provider was not making the caseworker aware of the missed or late appointments.
- 2. There was concern that the children were allowed to return to mother's care prior to her beginning her mental health services when that was the initial reported concern.
- 3. The FAST team believed that housing and financial stability were the critical elements in this case and that mental health was not a primary issue.
- 4. The Department did not view this case as a removal of the children from their mother's care and therefore did not formally complete the safety assessment tool to re-assess the safety of the children prior to the mother and children going to live in their new apartment on 2/20/2012. However, the caseworker and supervisor had discussed the safety of the children and spoke with the relatives regarding the safety of the children should they return to their

- mother's care, prior to this decision.
- 5. There was a two-week delay between the children's return home to their mother's care (2/20/2012) and the first contact by the in-home service provider (3/5/2012).
- 6. No Family Team Meeting (FTM) was held prior to the decision to return the children home to their mother's care, although the caseworker had discussed this separately with various family members.
- 7. The need for child welfare system, as a whole, to better engage fathers in the case planning and services provided to their children. The mother identified significant stress caused by the tension between herself and the victim's father and lack of financial support from him. The victim's father was invited to participate in the family team meetings but did not attend.
- 8. The lack of housing resources in the community where the family has established supports. The mother described feeling isolated in the new community and needing to take two busses to get the children to daycare and to her various appointments.

D. Recommendations for changes in systems, practice, policy, rule, or statute.

The CDHS Child Fatality Review Team reviewed the fatality and the county's prior involvements with the family and is making the following recommendation:

- 1. The Colorado Department of Human Service, Division of Child Welfare will utilize the Child Protection Task Group to determine if the difficulties identified in accessing mental health services in this case are a systemic problem across the state.
- 2. The Colorado Department of Human Services, Division of Child Welfare will recommend a change to policy requiring a re-assessment of safety when concluding the use of a safety plan.
- 3. The County Department will work with their contracted mental health providers to improve the timeliness of notification of client specific issues.
- 4. The County Department will include the mental health provider, as appropriate when child safety remains an issue, in decision making and case planning discussions regarding mutual clients.

E. Policy findings:

In the referrals, assessments, and case in this review, the following areas of case-specific non-compliance were noted:

1. The 5/27/2011 assessment was assigned a five-working-day response time but the victim was not seen by the Department until 6/17/2011. This is a violation of Volume VII, Rule 7.202.52A which states, "within the assigned response timeframe, the investigation shall include a face-to-face interview with or observation of the child who is the subject of a report of abuse or neglect." The Administrative Review Data for 2011 indicates the Department is meeting the assigned response time 73% of the time and making reasonable efforts to meet the assigned response time 84% of the time. This non-compliance issue occurred prior to the birth of the deceased child and had no impact on the overall casework delivery to the family. This policy finding is being addressed with the Department through continued monitoring and technical assistance.

F. Actions to be taken by County DHS and/or CDHS to address the identified systemic gaps and deficiencies in the delivery of services.

1. The Department has advised that all managers were instructed to remind their respective staff members that the risk re-assessment and a re-assessment of safety needs to be completed prior to reunification of a child in out-of-home placement with their parent/caregiver (per Vol. VII). Staff was also advised these assessment tools need to be completed prior to ending a safety plan (not currently required in Vol. VII). The CDHS, Division of Child Welfare will also provide coaching and technical assistance to Department staff on the use of the safety assessment as a decision making tool at the point of determining closure of a safety plan and

reunification.

- 2. The Department will pursue agreement from the two contract mental health providers that their agencies will immediately advise the referring and/or assigned caseworkers via email (or through one of our technology systems) of client status (missed appointments, closed case, etc.); all child welfare staff and the CDHS will be informed upon finalization of this process.
- 3. The CDHS, Division of Child Welfare will research to identify if the difficulties identified in accessing mental health services in this case are a systemic problem across the state. If it is determined this is a statewide problem the Division of Child Welfare will work with the Office of Behavioral Health and Health Care Policy and Finance to develop recommended solutions. If this is identified to be a county specific issue the Division of Child Welfare will offer assistance to the Department in working to find solutions with their local mental health centers.